BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **RONALD E. SHERER, M.D.,** Holder of License No. **19367** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-10A-19367-MDX **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Revocation)

On October 13, 2010, this matter came before the Arizona Medical Board ("Board") for consideration of the Administrative Law Judge (ALJ) Brian Brendan Tully's proposed Findings of Fact, Conclusions of Law and Recommended Order. Ronald E. Sherer, M.D., ("Respondent") did not appear before the Board; Assistant Attorney General Anne Froedge, represented the State. MaryJo Foster, Special Counsel with the Solicitor General's Section of the Attorney General's Office, was present and available to provide independent legal advice to the Board.

The Board, having considered the ALJ's decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The Arizona Medical Board ("Board") is the authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
2. Ronald E. Sherer, M.D. ("Respondent") is the holder of license number 19367 for the practice of allopathic medicine in the State of Arizona.
3. On July 6, 2010, the Board issued a Complaint and Notice of Hearing in Case No. 10A-19367-MDX, which consolidated the following cases charging Respondent with unprofessional conduct: MD-04-0380A; MD-07-0853A; MD-09-0226A; and MD-09-0229A. The Complaint and Notice of Hearing advised Respondent that an evidentiary hearing would be conducted before the Office of Administrative Hearings, an independent agency, on August 30, 2010, at 8:00 a.m.

4. The Board sent a copy of the Complaint and Notice of Hearing to Respondent at his address of record with the Board. At hearing, the Board presented evidence that the mailing of the Complaint and Notice of Hearing was received at Respondent's address of record in Rock Hill, South Carolina.

5. The commencement of the scheduled hearing was delayed 15 minutes to allow for the late arrival of Respondent or an attorney authorized to represent him. After the delay, the Administrative Law Judge conducted the hearing in Respondent's absence.

Case No. MD-04-0380A

6. On September 17, 2001, CM, a forty-year old woman, presented to Respondent at ten weeks gestation.

7. Respondent performed an amniocentesis and sent three vials of fluid to the lab for chromosome analysis. However, only one of the three vials was labeled.

8. The lab notified Respondent regarding the unlabeled vials. Respondent reordered the chromosome analysis study using the remaining vials.

9. There was no documentation that Respondent evaluated the lab tests of the one-labeled vial or followed up on the lab results of the reordered studies.

10. Respondent subsequently saw CM for three prenatal appointments, but he did not mention the chromosome testing results.

11. Subsequently, CM began seeing another obstetrician.

12. CM's infant daughter was born with chromosomal defects resulting in significant neurologic, anatomic, cognitive, and functional defects.

13. By letter dated March 19, 2004, Respondent's malpractice insurance carrier, Professional Underwriters Liability Company, submitted a Medical Malpractice Payment Report pertaining to a claim for Respondent's treatment of patient CM. After receiving that notification, the Board initiated Case No. MD-04-0380A.

14. By letter dated March 29, 2004, Board staff advised Respondent that the Board had opened an investigation in this matter. Respondent was requested to provide the Board with specified information no later than April 13, 2004.

15. By letter dated April 6, 2004, Respondent responded to Board staff's March 29, 2004 letter.

16. By letter dated December 13, 2004, Board staff advised Respondent that the following additional allegation was made against him based upon the Board's Medical Consultant's review: "Failure to maintain adequate records on the patient. (A.R.S. § 32-1401(27) (e) – Failing or refusing to maintain adequate records on a patient)."

17. On February 7, 2005, the Board received Respondent's written response to the new allegation.

18. The Board's Staff Investigational Review Committee ("SIRC") drafted a written Recommendation in this case reflecting its investigation performed on December 9, 2004, April 23, 2009, and April 30, 2009

19. The SIRC Recommendation set forth the following standard of care:

> The standard of care requires the treating physician to determine which tests are necessary and indicated for a given patient. Upon running the tests, he should evaluate the results and make appropriate recommendations and judgements. In addition, he should follow up on tests he knows have not been completed.

20. The SIRC Recommendation opined that Respondent deviated from the above described standard of care as follows:

> Dr. Sherer deviated from the standard of care by failing to completely evaluate the laboratory studies on the patient. Dr. Sherer was aware that ordered laboratory studies were not completed.

21. The SIRC Recommendation concluded that CM was harmed as follows due to Respondent's deviation from the above-described standard of care:

> Dr. Sherer failed to follow up on the missing amniotic fluid test (cytogenetic analysis), resulting in the patient being unaware of the fetal chromosomal defects. Subsequently, the child was born with significant neurologic, anatomic, cognitive and functional defects.

22. Ultimately, the SIRC Recommendation dated April 30, 2009 recommended the revocation of Respondent's allopathic medical license in this case.

23. Dr. William Wolf serves as the Board's chief medical consultant.

24. Dr. Wolf reviewed the Board's investigation in this case.

25. At hearing, Dr. Wolf testified that Respondent deviated from the standard of care by not evaluating the ordered lab studies.

26. Dr. Wolf opined that Respondent's deviation from the standard of care resulted in actual harm to CM's infant baby, who was born with neurological defects.

27. Dr. Wolf further opined that Respondent's medical records for CM were inadequate because there was no documentation that Respondent evaluated CM's lab tests and followed up on the test results.

Case MD-07-0853A

28. The Board initiated case number MD-07-0853A after the Board received a complaint on September 17, 2007, regarding Respondent's care and treatment of patient KJ, who was 24 years old at the time. KJ's father alleged that Respondent inappropriately prescribed multiple controlled drugs to KJ resulting in her overdose on those medications.

29. On May 8, 2007, KJ began treatment at Desert Pain & Rehab Specialist ("Desert") upon a referral from Dan Downs, M.D. for management of chronic temporomandibular joint ("TMJ") pain.

30. On July 26, 2007, KJ was referred to Respondent, who was practicing at Desert, for TMJ pain management.

31. Respondent and several other health care providers provided KJ with care and treatment for her TMJ. While under Respondent's care and treatment, KJ saw other health care professionals on 12 occasions for opioid medications, which demonstrated typical drug-seeking behavior often associated with substance abuse.

32. Respondent adjusted KJ's medication dosages, added medications, and provided early refills for short-action opioids, sustained-release opioids, and muscle relaxants.

33. There was no documentation in Respondent's records that Respondent obtained KJ's medical records from the other physicians, coordinated care, or communicated with KJ's other health care providers.

34. On September 7, 2007, KJ was admitted to the Mayo emergency department ("ED") for accidental opioid overdose after KJ had been discovered semiconscious at home.

35. The ED physician noted the following regarding KJ's numerous medications:

> [T]he patient has a surprising and concerning number of duplicate medications. What is most surprising is that the majority of them have been prescribed in the last month...Apparently these are all prescribed by one pain service...it does not seem that there is a coordinated pain management plan...the potential for accidental overdose in this patient seems to be huge...I have some difficulty seeing this patient under chronic pain management services for TMJ syndrome with such a surprising array of medications.

36. The ED physician opined that KJ's overdose was not suicidal in nature, but accidental due to "the array of medications available to her."

37. KJ was subsequently discharged from the ED. However, Respondent did not obtain KJ's medical records that indicated that she had overdosed.

38. On September 11, 2007, KJ self-admitted for inpatient detoxification under the care of another physician.

39. Carol Peairs, M.D. was assigned to this case as the Board's medical consultant.

40. Dr. Peairs is licensed to practice allopathic medicine in Arizona. She is board certified in anesthesiology with a subspecialty in pain medicine. She serves as the Board's in-house consultant for pain management.

41. At hearing, Dr. Peairs testified regarding Progress Notes from KJ's treatment by Steven C. Burns, M.D. on May 1, 2007. KJ presented to Dr. Burns with the following complaint, which was documented in the Progress Notes:

> [H]er pain persists, and she says the side effects of decreasing her narcotics are ruining her life. She has not followed through with getting records from her previous providers, saying she felt too bad to get out of bed. She wants me to call her craniofacial surgeon for her pain history.

42. In those Progress Notes, Dr. Burns' Plan, paragraph 2, documented his concerns about KJ:

> Note I talked with Dr. Dale, her craniofacial surgeon, and he said patient has been relatively noncompliant, preferring only to rely on narcotic pain meds. She has essentially refused to see a psychologist for him. He said, and I agree, that she needs to see an addiction specialist. He said she has real pain, but requires far too much narcotic for the pain problem she has. I spent over 30 minutes with patient, discussing the fact that she needs to get off narcotics, and that I was going to talk to Dr. Herbert, a pain and addiction specialist, regarding taking over her narcotic care. She understood, she said, and we also talked about her meds and the need to let us know several days prior to running out of meds in the future.

43. Dr. Peairs testified that Respondent is not a pain or addiction specialist.

44. Dr. Peairs opined that the information in Dr. Burns' Progress Notes would have been vital for Respondent to have received in treating KJ. Respondent did not obtain those Progress Notes.

45. Dr. Peairs prepared a written Medical Consultant Report and Summary dated December 6, 2007 ("Consultant Report").

46. Dr. Peairs' Consultant Report described the following Standard of Care #1:

> Prior to prescribing long term opioid medications for chronic non-malignant pain, appropriate evaluation of the pain problem and identification of the pain generator is standard of care. This evaluation includes a pain history, review of medical records, targeted physical exam, drug history including verification of current prescriptions, and consideration of concomitant medical/psychiatric problems that may impact pain management. Treatment plan should be individualized, and include consideration of a multidisciplinary approach.

47. Dr. Peairs' Consultant Report described the following deviation by Respondent from Standard of Care #1:

> Dr. Sherer, as well as the other providers at Desert Pain & Rehab Specialists, all failed to obtain medical records from the most recent treating physician, oral surgeon, and dentist. Records from each of these providers document the urgent recommendation to discontinue opioids, with the assistance of a psychiatrist or addiction medicine

specialist. Dr. Sherer failed to use an appropriate multidisciplinary approach which should have included communication and coordination of care with KJ's dental specialist.

48. Dr. Peairs' Consultant Report described the following Standard of Care #2:

> After the decision has been made to prescribe long term opioids for chronic pain, it is standard of care to closely monitor for, recognize, and follow up on problems suggestive of high risk for substance abuse or addiction. These problems include, but are not limited to, past history of substance abuse, self-adjustment of medications, early depletion of prescriptions, repeated early refill requests, reports of lost or stolen medications, physical signs of overmedication or intoxication, etc.
> Furthermore, particularly when red flags are present, standard of care requires careful reassessment prior to dose escalation and/or introduction of additional controlled substances with abuse potential.

49. Dr. Peairs' Consultant Report described the following deviation by Respondent from Standard of Care #2:

> Dr. Sherer failed to consider and/or respond appropriately to multiple red flags suggestive of substance abuse. Although Dr. Sherer had the medical records from Dr. Meyerowitz available, he failed to prescribe and/or monitor appropriately in a patient with reported past behavior suggestive of substance abuse. This includes prior history of urine drug screen positive for an illegal substance (resulting in discontinuation of care), and prior history of emergency room treatment for alcohol intoxication secondary to self-medicating for pain.
>
> Additionally, Dr. Sherer continued to provide escalating dosage and early refills despite a clear pattern of aberrant drug seeking behavior. This includes noncompliance demonstrative by repeated early depletion of medications prescribed by Dr. Sherer and others at Desert Pain & Rehab Specialists, report of stolen medications, self-medication to the point of appearing at an office visit "glazed over" and "glassy eyed", [*sic*] persistent use of medication that she had been instructed to discontinue, multiple calls of concern from pharmacists including pharmacy reports of use of deception to obtain refills, failure to use prescriptions for non-opioid medications (Lodine, Lyrica), all culminating in an emergency room visit due to "passing out". [*sic*]

50. Dr. Peairs' Consultant Report described the following Standard of Care # 3:

> Acute pain management and post-operative pain management in a patient already taking pain medications for chronic pain requires particular attention and coordination of care.
>
> The physician managing chronic pain, [*sic*] does not manage acute post-operative pain without the knowledge of and/or the express consent of the treating surgeon.
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> When the acute and/or post-operative pain is excessive, it is imperative that the attending surgeon is informed and that the patient is examined by the appropriate specialist for any potential complicating factor which may be contributing to the increased pain.
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> To do otherwise, [*sic*] poses the risk of masking post-operative complication(s), as well as exposing the patient to the risk of having excessive opioid inadvertently prescribed by multiple physicians.

51. Dr. Peairs' Consultant Report described the following deviation by Respondent from Standard of Care #3:

> Dr. Sherer failed to contact the surgeon prior to assuming responsibility for prescribing opioids for (presumed) acute post-operative pain.[1] He failed to contact the surgeon when KJ required escalating opioid dosages as more time elapsed from "surgery", [*sic*] which should suggest the possibility of post-operative complications. In this case, one phone call to the dentist would have identified that the surgery had not been performed, and that this was yet another red flag for substance abuse and addiction.

[Footnote added].

51 Dr. Peairs' Consultant Report described the following Standard of Care #4:

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[1] KJ had reported that she underwent dental surgery for her jaw, when actually she had not been a surgical patient.

> It is standard of care for a pain management physician to follow up on reports of medical problems potentially related to treatment provided.

52. Dr. Peairs' Consultant Report described the following deviation by Respondent from Standard of Care #4:

> Dr. Sherer failed to follow up and/or obtain the emergency room medical records after KJ specifically reported to Dr. Sherer that she was taken to the ER for "passing out" and that her medications had been confiscated. The failure to obtain these records is particularly egregious in a patient with history of repeated noncompliance including recent self-medication to the point of appearing "glassy eyed" and "glazed over". [*sic*]

53. Dr. Peairs' Consultant Report described the following Standard of Care #5:

> It is standard of care for a physician to recognize the limitations of his/her training and expertise, and to obtain specialist consultation for patients with complex problems outside the scope of their practice.

54. Dr. Peairs' Consultant Report described the following deviation by Respondent from Standard of Care #5:

> Dr. Sherer, an obstetrician/gynecologist, was outside his scope of practice in treating chronic [TMJ] joint pain with high dose opioids and muscle relaxants in a patient at high risk for substance abuse and addiction.
>
> Despite his inexperience treating chronic TMJ pain, he did not avail himself of the expertise of the dental specialist who was concurrently treating KJ. This is particularly aggravating, as this dentist has specialized training and an established practice dedicated to treatment of TMJ pain.

55. Dr. Peairs opined that Respondent's deviations from the above-described standards of care resulted in the following actual harm to KJ: the patient overdosed requiring emergency treatment; KJ required inpatient detoxification

from the medications prescribed by Respondent; and Respondent perpetuated KJ's addiction and drug-seeking behavior.

56. Dr. Peairs further opined that Respondent's deviations from the above-described standards of care subjected KJ to the following potential harm: "Respiratory depression, aspiration pneumonia, brain damage, and death from overdose due to inappropriate prescribing of controlled substances."

57. By letter dated December 26, 2007, Board staff gave Respondent an opportunity to address Dr. Peairs' Consultant Report.

58. Respondent's supplemental response to Dr. Peairs' Consultant Report was received by the Board on January 24, 2008.

59. After receiving and reviewing Respondent's response to the Consultant Report, Dr. Peairs issued a written Medical Consultant Report Re: Supplemental Response dated January 31, 2008 ("Supplemental Consultant Report").

60. In her Supplemental Consultant Report, Dr. Peairs concluded the following:

> The licensee [*sic*] supplemental response does not change any of the opinions regarding the multiple deviations from standard of care as outlined in the original Medical Consultant Report.
>
> Dr. Sherer's supplemental response raises additional professional conduct concerns of possible failure to comply with the Board's instructions to provide complete medical records and to retain confidentiality.

61. At hearing, Dr. Peairs testified consistent with her Consultant's Report and Supplemental Consultant's Report.

62. The Board's SIRC reviewed the investigation file against Respondent and issued recommendations dated May 14, 2008, April 23, 2009, and April 30, 2009. SIRC recommended the revocation of Respondent's license.

63. On January 22, 2009, the Board's case manager at the time, Celina Shepherd, [2] received a telephone call from the office of Ronald Bitza, D.O. advising that the office had been contacted by Walgreens pharmacy concerning a prescription received on January 21, 2009. The prescription contained the name of Michael Dubets, D.O., who was a former physician with Dr. Bitza's practice. The prescription also contained the name of Valentine Okon, P.A., with the physician assistant's practice address listed.

64. Board staff contacted Dr. Dubets, who said that he had not written the prescription.

65. Ms. Shepherd contacted PA Okon, who stated that Respondent had written the prescription.

66. Ms. Shepherd then spoke to Respondent, who admitted writing the prescription without his printed name appearing on the prescription.

67. By letter dated February 10, 2009, Ms. Shepherd informed Respondent that the Board was investigating his prescription for patient JB that did not contain his printed name on it.

68. Ms. Shepherd drafted an Investigative Report dated April 10, 2009, which concluded that Respondent violated the provisions of A.R.S. § 32-1968(C) by writing the prescription for JB that did not contain his printed name on it.

69. By letters dated April 10, 2009, and April 14, 2009, Ms. Shepherd sent Respondent a CD containing her Investigative Report and supporting documentation. She requested that Respondent provide the Board with a response to them.

70. Ms. Shepherd drafted an Investigative Report Addendum dated April 14, 2009, and April 21, 2009, documenting her attempts to contact Respondent, which were unsuccessful, as he had failed to provide the Board with a current address.

71. SIRC reviewed the Board's investigation and initially recommended a stayed revocation of Respondent's medical license on April 23, 2009. On April 30, 2009,

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[2] Ms. Shepherd currently serves as the Board's legal coordinator.

SIRC reconsidered this matter and amended its recommendation to revocation of Respondent's medical license.

MD-09-0229A

72. The Board initiated case number MD-09-0229A after receiving information that Respondent violated a Board Order requiring that he register for a Physician Assessment and Clinical Education ("PACE") evaluation by January 26, 2009.

73. By letter dated February 10, 2009, Board staff informed Respondent of the investigation and requested that he submit a complete response to the Board no later than February 24, 2009.

74. By letter dated February 24, 2009, Respondent's counsel responded to the Board's February 10, 2009 letter. Counsel advised the Board that Respondent lacked the financial ability to complete the PACE evaluation and counsel offered a proposal to reduce the scope of Respondent's practice to assisting in surgeries in lieu of the PACE evaluation.

75. Respondent has not enrolled for a PACE evaluation.

76. SIRC reviewed case number MD-09-0229A and recommended the revocation of Respondent's medical license.

Additional Prior Board Actions Against Respondent

77. On March 20, 2000, the Board and Respondent entered into a Consent Agreement and Order in Investigations Nos. 11223 and 11953. Respondent was issued a Decree of Censure and ordered to obtain 50 hours of continuing medical education in general obstetrics in addition to his required continuing medical education requirements for license renewal.

78. On October 12, 2001, the Board issued Findings of Fact, Conclusions of Law and Order in Board Case No. MD-00-0395 against Respondent. Respondent was placed on one year of probation and required to obtain 25 hours of continuing medical education in chronic pain management, addiction, and chemical dependency, which were in addition to the hours required for renewal of Respondent's medical license.

79. On October 1, 2006, the Board issued Findings of Fact, Conclusions of Law and Order in Board Case No. MD-05-0184 brought against Respondent. The Board Ordered that Respondent receive a Decree of Censure and placed on probation for 15 years, subject to specified conditions of probation. One condition of Respondent's probation was that he not practice obstetrics.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and the subject matter in these consolidated cases.
2. Pursuant to A.R.S. § 41-1092.07(G) (2) and A.A.C. R2-19-119(B), the Board has the burden of proof in these matters. The standard of proof is preponderance of the evidence. A.R.S. § 41-1092.07(G) (2) and A.A.C. R2-19-119(A).
3. Respondent's conduct described in the above Findings of Fact constitutes unprofessional conduct in violation of A.R.S. § 32-1401(27) (a), specifically A.R.S. §§ 32-1435(A) and 32-1968(C). The evidence of record supports this conclusion.
4. Respondent's conduct described in the above Findings of Fact constitutes unprofessional conduct in violation of A.R.S. § 32-1401(27) (e). The evidence of record supports this conclusion.
5. Respondent's conduct described in the above Findings of Fact constitutes unprofessional conduct in violation of A.R.S. § 32-1401(27) (q). The evidence of record supports this conclusion.
6. Respondent's conduct described in the above Findings of Fact constitutes unprofessional conduct in violation of A.R.S. § 32-1401(27) (r). The evidence of record supports this conclusion.
7. Respondent's conduct described in the above Findings of Fact constitutes unprofessional conduct in violations of A.R.S. § 32-1401(27) (ll). The evidence of record supports this conclusion.

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ORDER

Respondent's License No. 19367 shall be revoked by the Board on the effective date of the Order entered in Docket No. 10A-19367-MDX.

In addition to the above-provided Letter of Reprimand, Respondent is assessed the costs of formal hearing, pursuant to A.R.S. § 32-1451(M). Respondent shall pay the assessed costs of formal hearing within 30 days of billing from the Board, unless the Board or its designee grants an extension of time for payment.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 5th day of October, 2010.

THE ARIZONA MEDICAL BOARD

By _____
LISA WYNN
Executive Director

ORIGINAL of the foregoing filed this 15th day of October, 2010 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

COPY OF THE FOREGOING FILED this 15th day of October, 2010 with:

Cliff J. Vanell, Director
Office of Administrative Hearings
1400 W. Washington, Ste 101
Phoenix, AZ 85007

Executed copy of the foregoing mailed by U.S. Mail this 15th day of October, 2010 to:

Ronald E. Sherer, M.D.
Address of Record

Anne Froedge
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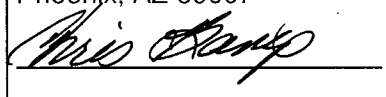

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